

11476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5616 Main St.		d. STREET ADDRESS 5616 Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle I. Last BAUMAN		4. DATE OF DEATH Month Oct. Day 24, Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Trainor		14. MOTHER'S MAIDEN NAME Lucretia Leishear	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. C. L. Haslup - Tuncany Apts. Balto. 10, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 260X DUE TO chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general arteriosclerosis DUE TO diabetes mellitus (c) 20 yrs INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1945 , 19 to Oct 22 19 59 , that I last saw the deceased alive on Oct 22 , 19 59 , and that death occurred at 8:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4609 Main St 10/24/59 DATE SIGNED ACTUAL SIGNATURE B B Brumbaugh M.D. PHYSICIAN'S NAME (Type) B B Brumbaugh Elkridge 27 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/59	
22c. NAME OF CEMETERY OR CREMATORY St. Augustines Cem.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lickner & Sons - Balto		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
ADDRESS 17th Md		24b. REGISTRAR'S SIGNATURE Arthur E. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

11477

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u> x <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pennapolis Junction Road</u>		e. STREET ADDRESS <u>Pennapolis Junction Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Josephine Edith Cooper</u> First Middle Last		4. DATE OF DEATH <u>October 28</u> 19 <u>59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14 1912</u> 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>distillery</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>
13. FATHER'S NAME <u>William Bond</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Reat</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-2565</u>	
17. INFORMANT <u>John Cooper - Jessup</u> Address <u>Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 171X DUE TO <u>Carcinoma of Cervix Uteri</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 yrs.</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 26</u> 19 <u>59</u> , to <u>Oct. 28</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 27</u> 19 <u>59</u> , and that death occurred at <u>330 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>10/28/59</u>	
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balt. National Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u> ADDRESS <u>Kennel Md</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - W. Friendship				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jct. of Burnt Woods Road & Rt. 32				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ann Middle Eastman Last Davis				4. DATE OF DEATH Month October Day 19 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, '59	
9. AGE (In years last birthday) 8		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Olney, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Clarence C. Davis				14. MOTHER'S MAIDEN NAME Helen Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Clarence C. Davis, Upside, Ellicott City Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull & extensive brain damage DUE TO instant 822X Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child bumped head in car which turned over			
20c. TIME OF INJURY Month, Day, Year 9:00 p.m. 10-19-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road		20f. (City or town) Howard (County) Howard (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-59		22c. NAME OF CEMETERY OR CREMATORY Forest Park		22d. LOCATION (City, town, or county) (State) Houston, Texas	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE OCT 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2073386XV8

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG251 11-2-59 et

11461

11479

CERTIFICATE OF DEATH

Reg. Dist. No. 195

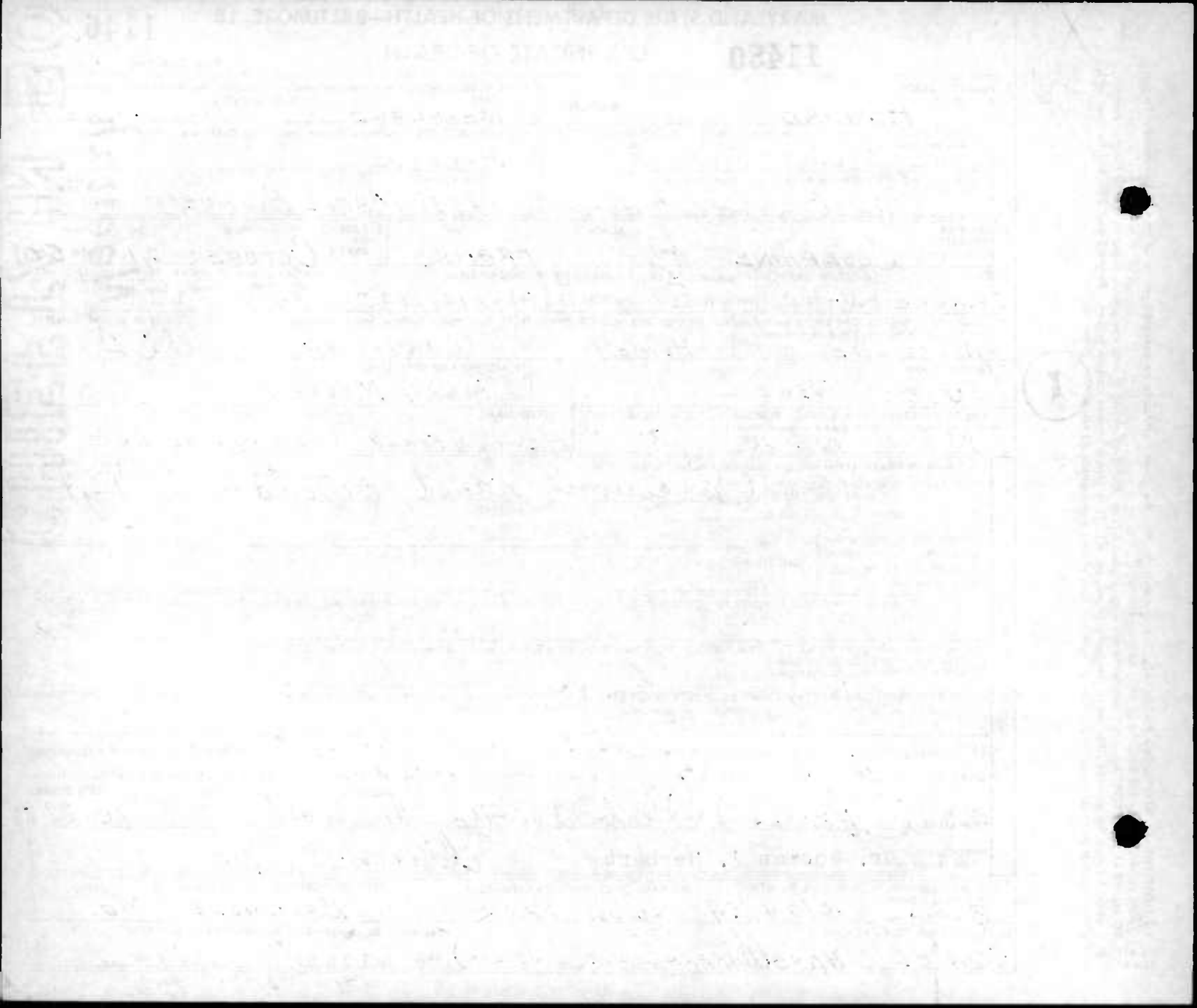
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Cobb</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Junction</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Private residence"</u>		d. STREET ADDRESS <u>Acworth</u> <u>49X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Lula</u> First <u>Victoria</u> Middle <u>Dewberry</u> Last		4. DATE OF DEATH <u>October</u> Month <u>8</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March</u> <u>1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cann</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>J. B. Dewberry</u> Address <u>Annapolis Junction</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO <u>Hypertensive Cardis-Vas. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 4</u> , 19 <u>59</u> , to <u>Oct. 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 8</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Georgia</u> DATE SIGNED <u>10/9/59</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 11, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Acworth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

11480

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, ELLICOTT CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaeffer's Convalescent Home		d. STREET ADDRESS 1235 MAPLE AVENUE	
3. NAME OF DECEASED (Type or print) JOSEPHINE F. FRANK		4. DATE OF DEATH OCTOBER 21 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1925
9. AGE (In years lost birthday) 34 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUSTIS NEWELL		14. MOTHER'S MAIDEN NAME MARY MOLLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HENRY M. FRANK		Address 1235 MAPLE AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast, metastatic 170X DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 20 , 19 59 to Oct 21 , 19 59 that I last saw the deceased alive on Oct 20 , 19 59 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 446 Church St. Ellicott City, Md. DATE SIGNED 10-22-59 ACTUAL SIGNATURE Thomas F. Herbert, M.D. PHYSICIAN'S NAME (Type) Dr. Thomas F. Herbert			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/24/59	22c. NAME OF CEMETERY OR CREMATORY LODGE PARK	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE L. SCHWAB (BARBARA SCHWAB SUCCESSOR)		24a. REC'D BY REGISTRAR OCT 26 59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Christina S. Hanna	



1X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
1148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11463														
1. PLACE OF DEATH a. COUNTY Howard MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY New Rochelle									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New Rochelle									
c. LENGTH OF STAY IN 1b U.S. Rt. 40 - 1 1/2 miles west of Friendship Airport					d. STREET ADDRESS 33 Park Avenue									
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ATTILIO XXXXXXXXXX					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Attilio					4. DATE OF DEATH GALLO October 31, 1959									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1932		9. AGE (In years last birthday) 27 yrs.						
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardener					10b. KIND OF BUSINESS OR INDUSTRY New York					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Michael Gallo					14. MOTHER'S MAIDEN NAME Carmela Chirchelli									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown					16. SOCIAL SECURITY NO. unknown					17. INFORMANT Sisto & Paino Funeral Home New York				
					Address New Rochelle									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries and 3rd degree burns DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH PARTIAL				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-tractor trailer collision					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year 9:45 10/31 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road			20f. (City or town) (County) (State) Ellicott City, Howard, Md.						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE William V. Lovitt, Jr.					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 11/2/59				
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11/6/59		22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cem.			22d. LOCATION (City, town, or country) (State) New Rochelle, New York						
23. FUNERAL DIRECTOR Howard H. Hubbard					ADDRESS 4107 Wilkens Avenue					24a. REC'D BY REGISTRAR NOV 4 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kraus		

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE New York b. COUNTY New Rochelle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rt. 40 - 1 1/2 miles West of Friendship Airport		d. STREET ADDRESS 33 Park Avenue	
3. NAME OF DECEASED (Type or print) PATTI		4. DATE OF DEATH Month October Day 31, Year 19 59	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/40	
9. AGE (In years birth day) 19		10. IF UNDER 1 YEAR Months 19 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER BRUNELLE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 265-60-4602	
17. INFORMANT SISTO & PAINO FUNERAL HOME		Address 109 ORCHARD AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries and 3rd degree burns 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PARTIAL		INTERVAL BETWEEN ONSET AND DEATH NY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto-tractor trailer collision	
20c. TIME OF INJURY Month, Day, Year 9:45 10/31 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Ellicott City, Howard, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11/2/59		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/6/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		22d. LOCATION (City, town, or country) (State) New Rochelle	
23. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

Howard N. Hubbard 4107 Wilshire Ave.

Walter J. Jones, Jr.

10/25/50 Road Agent, Illinois State Police, Ill.

Passenger in auto-truck trailer collision

no

1

housewife

Burlington, Vermont
U. S. A.

33 Park Avenue

New Rochelle

New York

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11483

Reg. Dist. No.

11465

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. 1615-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Rest Home				d. STREET ADDRESS 8202 Adelphi Road			
3. NAME OF DECEASED (Type or print) Joseph Patrick Gowen Sr.				4. DATE OF DEATH October 29, 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1884	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Thomas Gowen				14. MOTHER'S MAIDEN NAME Bridget Ann Meeham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Nellie G Gowen Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 days 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-27-, 1959 to 10-29-, 1959 , that I last saw the deceased alive on 10-26-, 1959 , and that death occurred at 6:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker M.D.							
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.				Clarksville, Md. 10-29-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 31, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Charles S. Whitaker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (Page 3) and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11466

1. PLACE OF DEATH a. COUNTY HOWARD 11484 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City Rural c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 4				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Route 4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle M. Last MANNER				4. DATE OF DEATH Month October Day 30 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lawrence J. Manner				14. MOTHER'S MAIDEN NAME Elnora T. Madigan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-6938		17. INFORMANT Pauline C. Manner, Ellicott City, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic asphyxia 912.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
2Da. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Farm tractor overturned, pinning him under it					
20c. TIME OF INJURY 9:45 a.m. 10/30 59		2Dd. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Ellicott City Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr.		M.D. W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/30/59	
EXAMINER'S NAME (Type) F.C. Higinbotham		ADDRESS Ellicott City, Md		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or country) (State) Baltimore, Md	
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

146

MAINTAIN THE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1188

WESTLAND

Albion City, MI

Albion City, MI

GUARD

Dec 13, 1911

Albion City, MI

Albion City, MI

Albion City, MI

Albion City, MI

218-1-2218 F. Line C. Warner, Albion City, MI

No

Thomson's

1st. Grand Jury, Albion City, MI

in.

Albion City, MI

Albion City, MI

1030 22

218

1030 22

Albion City, MI

Albion City, MI

Albion City, MI

11-22

Albion City, MI

Albion City, MI

Albion City, MI

11485

CERTIFICATE OF DEATH

Reg. Dist. No. 11467

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b Ellicott City		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Montgomery Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM F. REX		First		Middle		Last		4. DATE OF DEATH Month Oct. 31 , 1959 Day 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1910	9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months 49	IF UNDER 24 HRS. Days 49	Hours 49	Min. 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Owner		10b. KIND OF BUSINESS OR INDUSTRY Gasoline		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frederick Rex				14. MOTHER'S MAIDEN NAME Bertha Huber					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-5964		INFORMANT Mrs. Mae Schoene, Ellicott City, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE								INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 30 MIN. 10 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Columbia Road		(County) (State)	
21. I certify that I attended the deceased from 10-31 , 1959, to 10-31 , 1959, that I last saw the deceased alive on 10-31 , 1959, and that death occurred at 10:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Columbia Road DATE SIGNED ACTUAL SIGNATURE P. V. Thorpe M.D. Ellicott City, Md. PHYSICIAN'S NAME (Type) Peter V. Thorpe M.D. Ellicott City, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran		22d. LOCATION (City, town, or county) Pfieffers Corner, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hump			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

Married Single Widowed Divorced

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11486

CERTIFICATE OF DEATH

Reg. Dist. No. 11468

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine 2, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Old Annapolis Road</u>	
3. NAME OF DECEASED (Type or print) <u>First LLOYD Middle L. Last SMITH</u>		4. DATE OF DEATH <u>October 9 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William T. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maria Coffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.#1</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Myrtle V. Smith - Woodbine 2, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, Hypertension</u> DUE TO (b) <u>Asthma,</u> DUE TO (c) <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1957</u> <u>to</u> <u>9 Oct 59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>9 Oct 1959</u> , that I last saw the deceased alive on <u>9 Oct 1959</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Shelville, Md</u> DATE SIGNED <u>9 Oct 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		Syrkesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, Howard, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Haight</u>		ADDRESS <u>Shelville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 13 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hall</u>	

